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# Alkies, and Druggies, and Wackos! Oh, My!

## Transforming the Delivery of Community-Based Substance Abuse/Mental Health Treatment and Rehabilitation

Choices Longitudinal Study  
IRB# EXE 05-032  
IRB# EXE 05-032-02

Sean E. Zullo



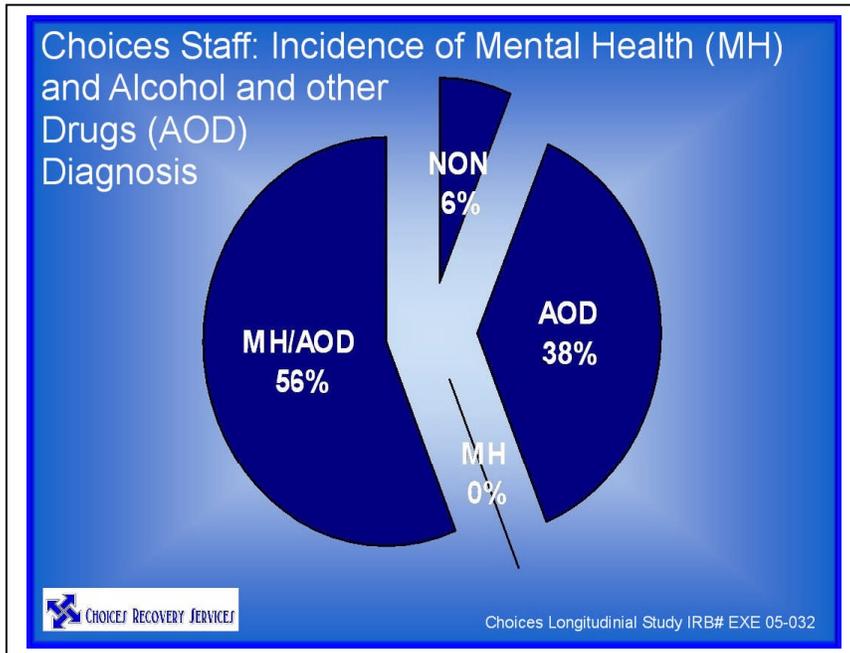
# Alkies, and Druggies, and Crazies! Oh, My!

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For many, the idea of having a co-worker that is an alcoholic, drug addict, or mentally ill elicits fear and consternation among many within the field of mental health, substance abuse treatment and rehabilitation. I have witnessed program directors, supervisors, human resource managers, and line-staff react with varying degrees of apprehension when confronted with the possibility of including consumers within their agency's treatment team. It seems that many agencies suffer from a form of workplace NIMBYism. There exists strong agreement within the recovery/treatment community of the value of utilizing consumers in the delivery of recovery services; what seems to be the sticking point is which programs are "best suited"? Individuals are quick to point at "other" programs that may be better suited over "their" program. Many program directors' staff supervisors are exceedingly reluctant to seriously consider including consumers within the delivery of recovery services.



But *why* is that? Within Twelve-Step/Self-Help treatment modalities peer mentoring and peer program delivery are fundamental components. There exists a multitude of quantifiable reasons for exploring the utilization of consumers as an important component of any addiction/mental health treatment team (see diagram at left). The practice of utilizing consumers as part of the treatment and rehabilitation team is hotly debated and valued in theory, but rarely practiced on any scale.

This document will provide an overview of Choices of Long Beach, Inc.'s "Choices" mission of utilizing those in stabilized recovery to assist

those attempting to recover from mental illness and drug and alcohol addiction. Central to this discussion is the comparison of the proposed methodology to existing "traditional" approaches. This includes a discussion of a practical working model of treatment for consumers by consumers, and the resultant comparative results. My hope is this document will provide a framework for real discussion and possible implementation within agencies.

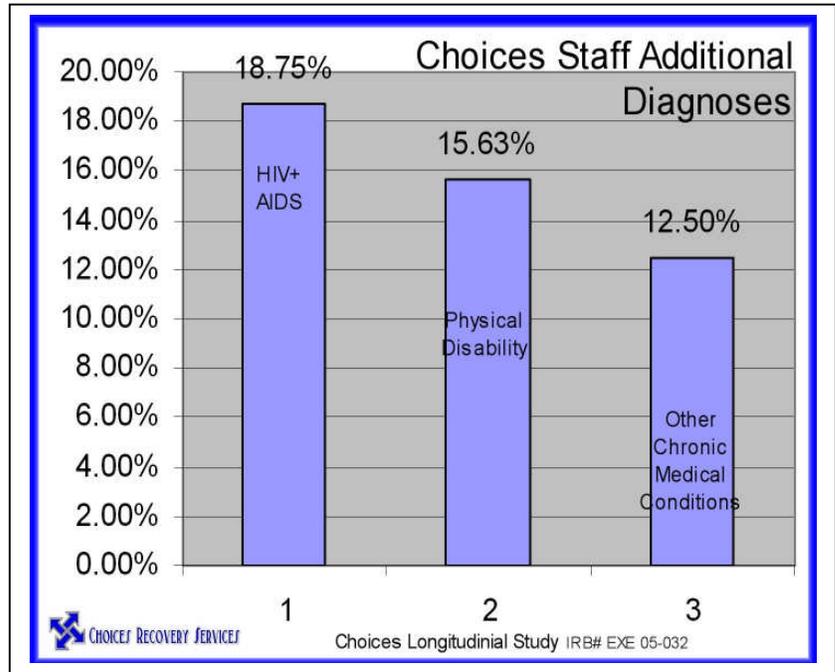
First, let's look at a recent example of healthcare system change similar in scope to that discussed within this document. In the mid-80s, I remember Rock Hudson standing next to Doris Day telling the world that he had AIDS. The world was forever changed, as was the delivery of medical treatment in the western world. Let me explain.

What unfolded was amazing. AIDS survivors started doing something revolutionary; they started asking questions, demanding answers, and making their voice heard. AIDS patients regularly fired their doctor, lobbied drug companies, and strong-armed politicians. They started showing up at medical conferences and demanding the right to be part of the delivery of their medical treatment. Out of New York, came ACT-UP (Aids Coalition to Unleash Power), and the medical establishment started to take notice and change.

This change took many forms, one of which included the introduction of alternative healing therapies: I remember mushrooms, vitamins, Chinese herbs, macrobiotic diets, Chiropractic care, meditation, prayer, crystals, spiritual healing, and many more. I witnessed doctors (who previously dismissed these “bogus” treatments) slowly accept the fact that non-traditional treatment approaches could sometimes produce the desired results.

In the early days people were regularly fired over the rumor of having AIDS (Philadelphia). Today the thought of not having HIV+/AIDS staff within an AIDS service organization is ludicrous. HIV/AIDS survivors were the pioneers in bringing care to not only themselves, but their fellow survivors. Not only were those early advocates assisting others, but they were also healing themselves in the process. I see striking similarities within mental health and addiction. There are strong arguments for the treatment value of consumer providers, but there is also great therapeutic value to those providing that care, and I see this as a true win-win arrangement.

The recovery at issue lies with the individual, and it is the right of each person to participate in this process. Social service and counseling within HIV/AIDS service organizations is largely done by those within HIV recovery, and the contribution of these staffers is clearly valuable and effective. Why shouldn't those with co-occurring disorders “COD” (mental illness/drug and alcohol addiction/Medical/physical) assist in the treatment and rehabilitation of program participants seeking recovery assistance (see diagram above)?



## Potential Advantages

### Understanding, Hope, and Motivation

By far, this is the most important aspect of having staff that is recovering/recovered from alcohol/drug addiction and mental illness. Many entering Choices are exhausted from their struggles with mental illness and addiction, and having someone who has accomplished some level of recovery gives them hope. Witnessing living breathing examples of recovery success assists those struggling day-by-day to maintain the hope of having a productive life. Motivation from someone in recovery that has experienced the pitfalls and setbacks of addiction and mental illness also allows a level of identification and understanding otherwise out of reach to those non-addicts or non-mentally ill.

Having personal experience also allows a consumer provider an insight to addiction and mental illness only available through first-hand experience. This personal experience is critical when an individual attempts to manipulate staff for negative or destructive behaviors.

### Trust and Empathy

Frequently, an individual entering treatment with a mental illness and chemical addiction will require implementation of a treatment plan immediately addressing both conditions. Symptoms of paranoia, distrust, and delusions are signs and symptoms of many mental conditions and chemical addictions. Understanding this fact from learned experience allows a counselor to connect with COD program participants and develop an initial rapport. This connection may allow the counselor to draw on the trust and understanding of the individual's current condition to garner initial or continued program compliance. This shared experience may allow the program participant to feel more comfortable during chemical detox, medication reintroduction, possible medication side effects, and the stress of settling into a new environment. Experiential knowledge is hard earned and many new to treatment find it reassuring to know that they are connecting with people who are "just like them".

## Potential Challenges

### Tunnel Vision

Not seeing the big picture – this may lead to a narrowing of therapeutic options for the provider. An individual finding recovery within a specific treatment modality may become "married" to that specific recovery method. Within 12-step recovery programs it's not uncommon to hear someone called a "Step-Nazi", referring to a person who believes in the strict adherence to 12-step principles. It's not uncommon to hear these old-school 12-stepers dismiss therapy and psychotropic medication as "non-recovery". Another variation is the idea of abstinence as a condition of drug and alcohol treatment. The strict adherence to an abstinence only recovery program discounts the possibility of relapse in the recovery process.

Religious based, medication based, and CBT based are all examples of treatment modalities that a person finding recovery could become convinced is the most effective or best practice. A possible mitigating program development strategy may include actively staffing an agency staff deeply rooted in treatment diversity.

## On a Mission

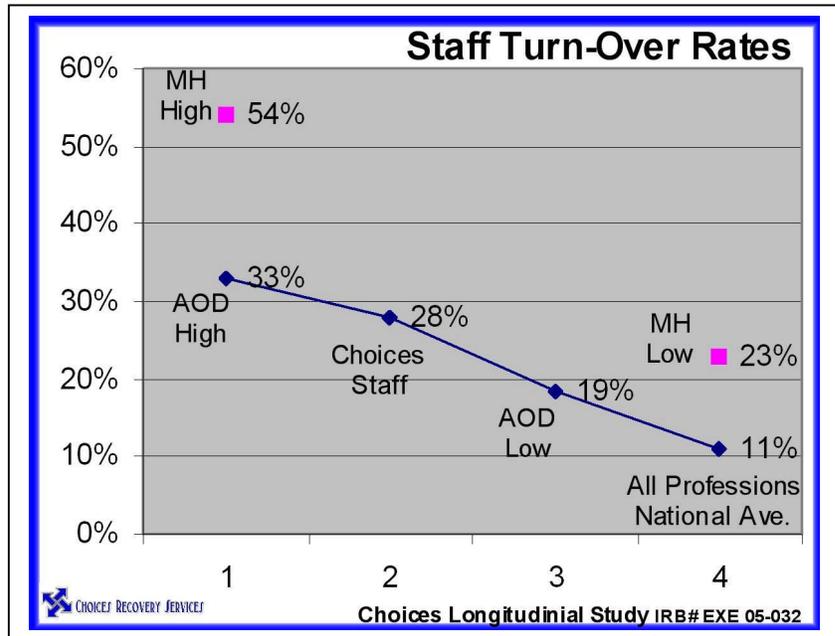
Helping others and wanting to give back is a cornerstone of this recovery model, but it is easy for an individual to forget themselves and give at the cost of their own recovery. Maintaining healthy boundaries is a learned skill requiring the understanding and ability of staff to put their needs first when necessary. This is an artful balance, but by no means unique to those in the COD treatment field.

Many attribute the issue of personal boundaries as a major contributor to the high industry-wide turnover rates. It is not uncommon for individuals entering this field to suddenly realize the great demands and suddenly find themselves ill prepared for the position. Allowing staff to grow into their position is one method of combating burn-out, ongoing review of agency turnover rates, and acknowledgement of staff stress relief needs.

## Myths and Choices' Findings

**Myth: Agencies will experience prohibitively high staff turn-over rates resulting in lack of tenure among staff.**

During the past twelve months (ending 10/31/06), Choices staff turn-over was 28%. While this rate is high for most businesses; staff, within the drug and alcohol treatment agencies, average anywhere from 19%-33% (SAMSHA Kaplan, 2003). Looking at substance abuse only, Choices' turnover rate was on the high side of average, but that is not including the mental health staff. Now, looking at staff of community-based mental health agencies, the turnover rate starts at 23% and the high is 54% (HSRI-Kadis, 2003). Averaging both mental health and substance abuse staff turn-over rates provides us with a rough

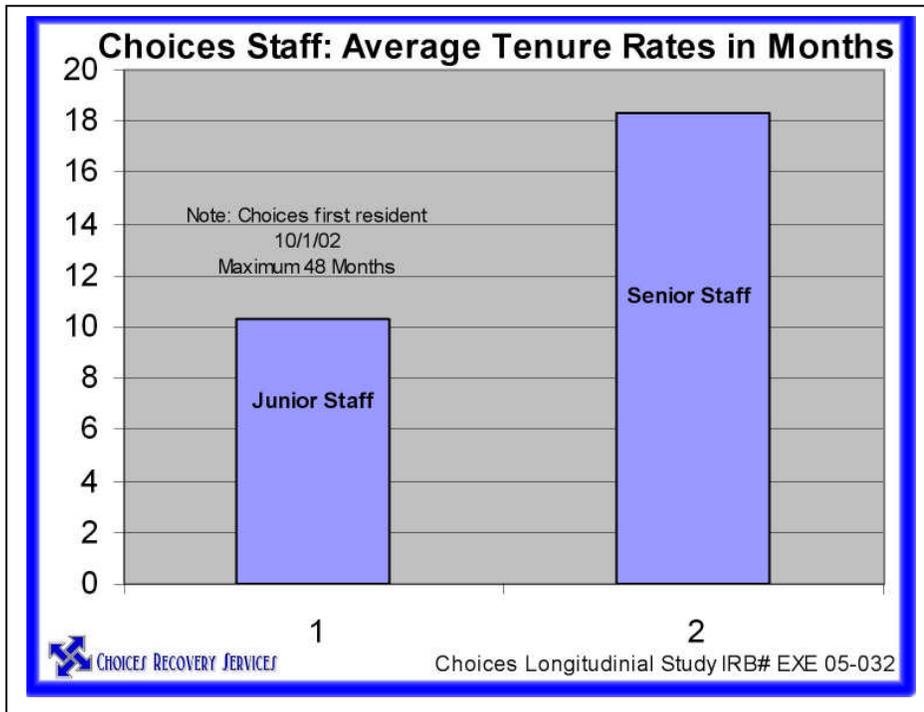


estimate of a national COD program (not unlike Choices). These results are 44% as the high estimate and 21% as the low. By looking at the combined figures, it clearly illustrates the turn-over rate for Choices is in the lower half of the national average. By comparison, the national average for all professions is 11% (see diagram above).

Related to increased turnover is decreased tenure, or the belief that staff will not stay on the job long enough to acquire needed "learned" experience. Over a period of time an individual "learns from experience", and becomes more skilled allowing for increased job performance, growth of duty capabilities, and skills necessary to manage a wider variety of challenges. Experienced staff requires

less management supervision, and over time, can assume leadership positions, training less skilled staff. An organization that is constantly retraining its entire staff could find its effective delivery of services seriously compromised.

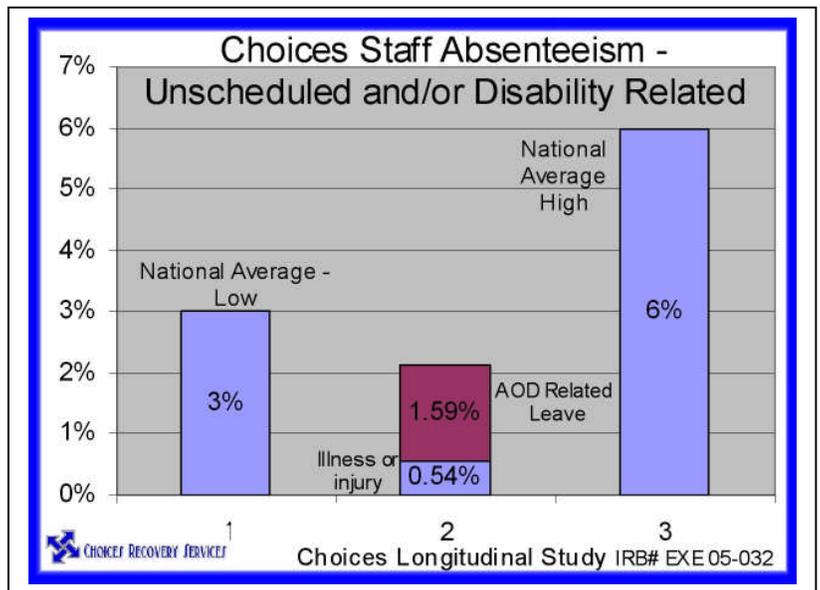
The graph on left illustrates the average length of staff tenure for both junior and senior positions. Junior staff at Choices average 10 months experience and senior staff average 18 months. While those numbers may not be extremely exciting at first glance, when the age of the company is added (48 months) it becomes clear that



staff retention numbers are extremely sound. Also note: all junior staff positions were created in the past 12 months.

**Myth: Agencies will experience excessive staff absenteeism (unscheduled and/or disability related).**

Absenteeism is a constant concern within all organizations. The days of employee/employer loyalty and guaranteed career longevity are long over. Not only will individuals have many jobs over their working years, but now it is accepted that individuals will average many careers. This has produced an environment where employees are looking to change jobs and companies are always looking to keep labor costs down, thus increasing market presence by aggressive competition for limited resources. Absenteeism plays a large part of this equation. Nationally, companies average 15% employee absenteeism across the board. This includes vacations, sick days, personal days, and unscheduled absences. In this discussion, let's look at absenteeism related to disability/illness and unscheduled absences. By looking at these numbers, we can isolate the direct cost incurred by Choices as a product of time lost due to recovery-related absences. As illustrated in the graph, national averages range from 3-6%, and Choices' rate is comfortably in the middle of that range (see graph bottom at right). Once again, comparative results for loss



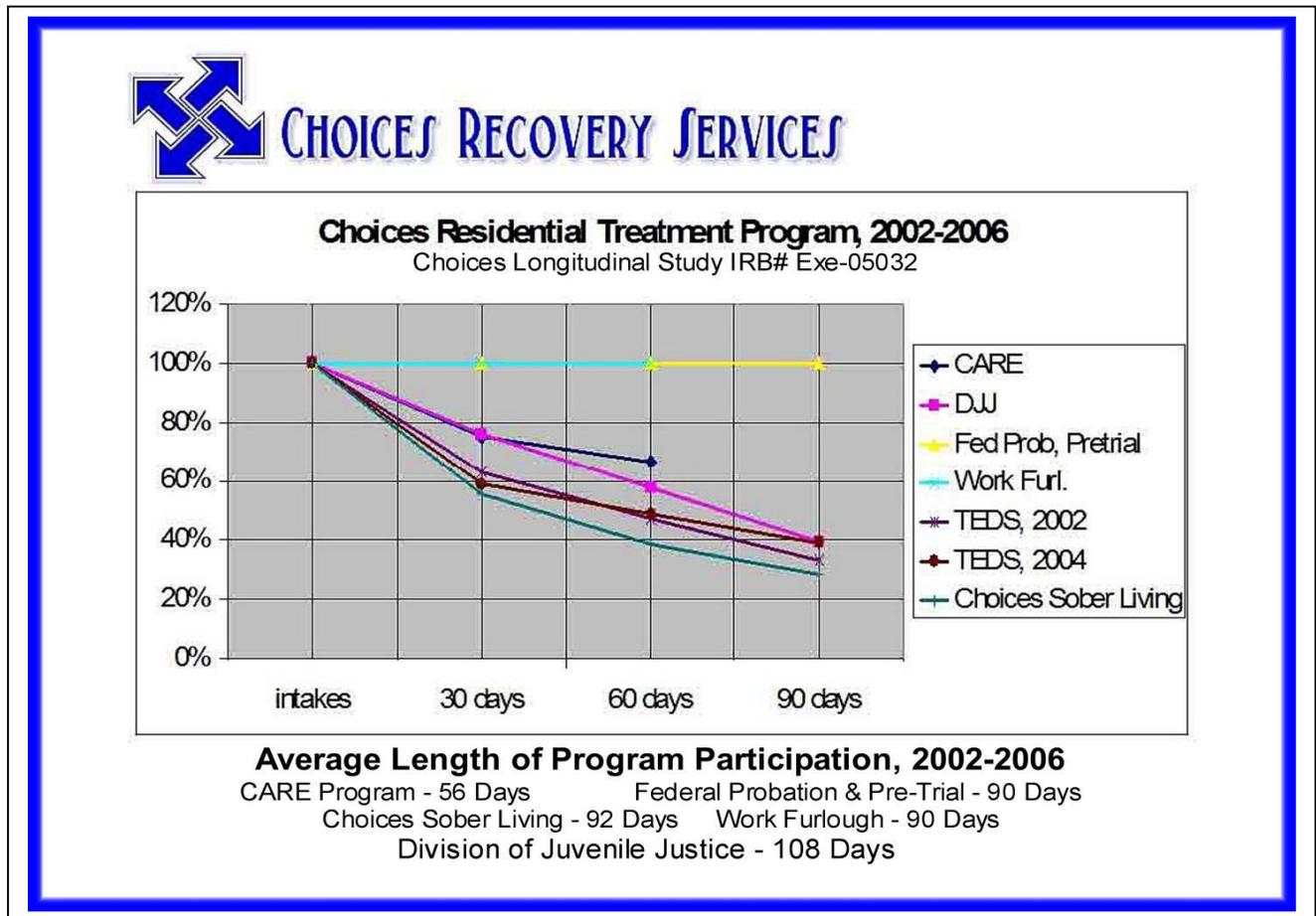
indicators maintain a comfortable mid-range position. Note: this analysis also includes time off given to individuals for realigning their recovery prior to coming back into a Choices position after hospitalization or relapse.

**Myth: The program’s treatment efficacy will be compromised.**

As the Executive Director, the smooth and effective operation of our program is a daily concern. This is our primary mission and our company’s values must remain unwavering in this regard. Choices operates under a strong ethical obligation to provide the very best program possible, and the development of any conditions that hinder or jeopardize the delivery of this assistance must be swiftly addressed and resolved.

Choices has always utilized consumers within the delivery of treatment and rehabilitative services, so it is impossible to provide competitive results of our program operating under pre and post consumer/staff implementation. Illustrated in the graph (directly below) are Choices program completion rates (for various programs at Choices) as compared to national program completion rates (TEDS 2002, 2004) utilizing data compiled by SAMSHA on an annual basis.

Choices’ programs at 30 and 60 days are substantially higher than that of national averages. Our numbers illustrate Choices’ effectiveness as compared to residential AOD programs for the same treatment period (s).



## Key Staff Management Components

**Work Environment** -Provide an environment that allows people to fail without experiencing “personal failure”.

**Patience** – Enough said.

**Understanding Relapse of Staff**– Mental health/AOD relapse is not unlike any other reoccurrence of an illness. While the AOD relapse may be more intense, periods of extended recovery can drastically improve the quality of life. Relapse is not necessary, but may be thought of as taking a step closer to the individual finding the combination of approaches needed to improve recovery results. A common AOD treatment approach utilizing this belief includes modified abstinence/harm-reduction.

**Develop Brief Intervention Strategies** – Develop a procedure for addressing relapse quickly, fairly, and effectively to achieve the desired results. Always with the understanding that relapse can be a learning experience. It is an opportunity for change, and not a moral failing.

**Desire Motivation**- Understand and utilize the strength of desire motivation within management strategies. The desire of staff to cooperate and collaborate as a team is central to the implementation of a successful staff development and retention plan.

**Flexibility** – Understand the balance of flexibility in the work environment and maintain minimum performance standards. Flexibility must not come at the expense of standards of care.

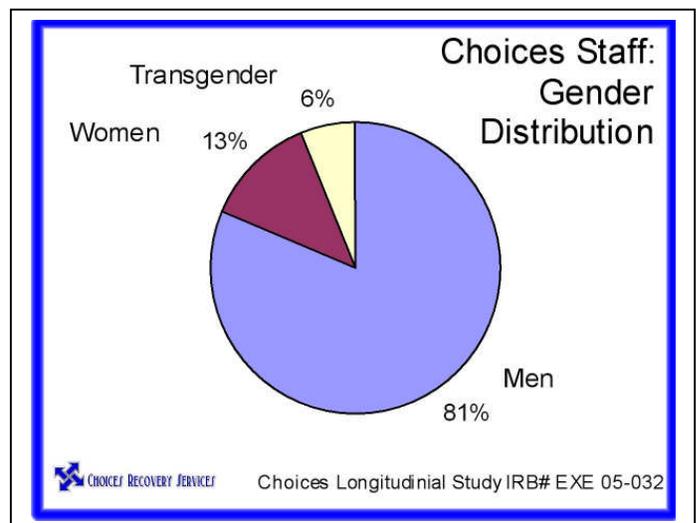
**Train, Train, Train,** - Putting someone in a position in which they are ill suited is setting the stage for a disaster. This is a mistake that many managers make.

**Incorporate Recovery Standards into Staff Culture** – Capitalize on the fact that staff are in recovery. Develop strong recovery motivation within staff culture.

**Start all Staff off Small and Slow**- Small projects allow staff to gain necessary self-confidence. This is critical for someone unsure of themselves, or someone acclimating to the workplace after an extended absence.

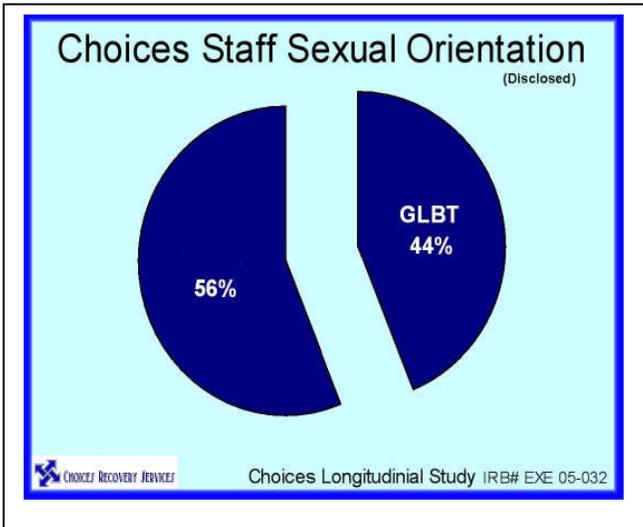
**Allow for Pressure Relief** - Always allow staff an easy way out of stressful situations. Allow staff to take personal time needed to cool off, regroup, go to a meeting, or make medical appointments, etc. A good manager knows the staff warning signs, and moves quickly to avoid melt-downs.

**Actively Promote Staff Diversity** – Choices staff have always represented the population they serve. Currently, staff comprise 78% White, 22% People of Color. The national average for substance abuse treatment professionals is 70-90 % White (SAMSHA- Kaplan, 2003). Choices staff is 81% male (see graph above). This figure accurately



represents the male treatment population at Choices. The national average for staffing is predominantly female (50-70%), but the treatment population is largely male.

While sexual orientation of staff is a non-issue within our recovery team, we have seen the desire of various program participants who at intake or during the course of treatment express the need/desire to discuss their sexual orientation issues with GLBT staff. Many times as part of their mental health and/or drug and alcohol relapses there were instances of GLBT related occurrences or feelings. Providing the staff that could identify with these occurrences and are understanding of the difficulty of some individuals to address these issues, allow program participants to feel at ease and confident their issues will be addressed in a safe and supportive environment. There seems to be a similarity in the acceptance process for individuals in denial with sexual orientation, mental health diagnosis, chronic medical conditions (HIV/HepC), and drug and/or alcohol addictions. Currently, Choices staff identify as Straight 56%, GLBT 44% - (see graph at left). Also, this distribution represents the increased representation of GLBT within our program population and within the local community surrounding our facilities (Long Beach, Silverlake).



**Maintain Standards-** Understand the minimum requirements of each staff position and staff accordingly. Someone providing counseling services must meet the requirements of the position to be staffed in that position. It must be clearly delineated what the requirements and expectations of each position are within the organization.

## Program Operations

**Staff Development and Engagement** – You can't give what you don't have. Accepting this, it is understood that the person in the sole giving position has developed the skills necessary to provide these services without requiring direct supervision or training. If this is not the case, staff support will be provided.

**Utilize Technology** - Understand and utilize all forms of technology. Train unfamiliar staff.

**Cross-Training Policies** – All Choices' staff are cross-trained for other positions within their department. All program staff understand program operations, program processes and participant policies. Likewise, intake staff are trained in all aspects of the intake process and can cover for co-workers when absent or needed elsewhere.

**Shadow Management/Training for Staff-** Related to cross-training techniques, shadow management is similar to on-the-job training or an apprenticeship program.

**Staff Smart-** Place people in jobs they like to do. Experience has proved that it is more important that they like the job rather than they are needed in that position. Allow staff to find their niche within the organization. This is linked to desire motivation. This requires good feedback between management,

staff, and consumers. Good staff will stay motivated in positions they do not find of interest for a short time, but for long-term stability and happiness, staff should feel connected to their position. When this works, staff will perform better; have greater job satisfaction, and increased tenure.

**Expand Communication-**

- Constant contact within staff – Choices provides all senior staff with cell phones and reimburses all junior staff for their phones. Current staff – 82% have cell phones.
- Email – All offices and homes have computer access, and all staff have email addresses

**Authority and Accountability-** Staff roles should be clearly defined so there is no question of individual staff responsibility. Staff are allowed areas of sole responsibility and are held accountable for those tasks assigned.

**Breaks/Suspensions/Time-Outs** – Time off can be used for discipline, recuperation, or reward.

**Peer Support** – Promote bonding between staff members.

**Command Structure Clearly Defined-**

- House Captains – Senior House Captains – Junior Coordinators- Senior Coordinators – Program Directors – Executive Directors
- Executive Director always available if previous steps are ineffective in resolving the issue.

**Empower Staff** -Allow staff to make decisions and support those decisions when appropriate. Choices' staff is required to have information explained to them if they are confused or unsure of directions or expectations.

**All Junior Staff** – Choices' junior staff are initially required to live on-site with senior staff and participate in shadow management training.

**Dress:**

- Collared shirts for men – no t-shirts, staff shirts provided to all.
- No beachwear for men or women.
- Clean and presentable clothing and physical appearance.
- Violation of these standards require the individual to change and come back to work.

**Tardiness-** Cell phones assist constant contact. Teaming allows people to assist each other in getting up and out of bed when being late is related to mental health symptoms.

**Medical/Mental Health** – Medical and mental health concerns are always referred to professional healthcare providers. Possible concerns include medication issues, chronic illness, substance abuse, etc.

**Promote Recovery** - Staff are required to have a 12-step sponsor (if substance abuser) and mental healthcare provider for staff with mental illness. Always leave the door open for return from relapse if appropriate.

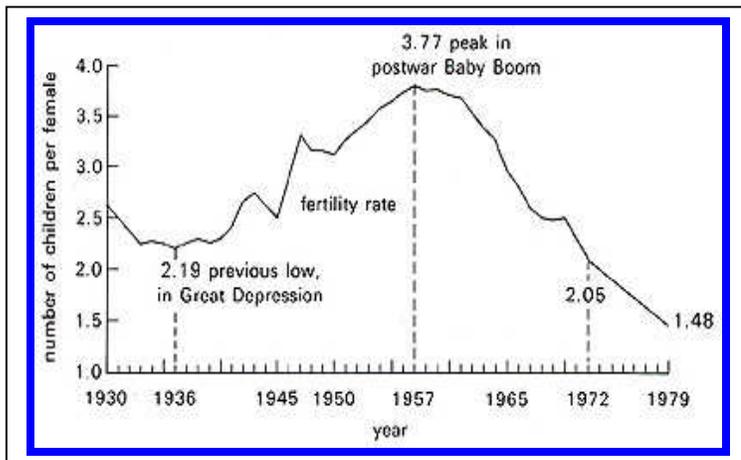
**Compensation** - Primary to any discussion of compensation is the understanding of how wages are linked to productivity in various fields. Experience has taught me a few best practices for Choices' staff.

- Short payment cycles (weekly).
- Performance based pay – Weekly pay triggered by completed paperwork approved by supervisor – Motivation for completing paperwork maintained weekly.
- Additional pay incentives for meeting and beating schedules or quotas.
- Timely reviews and raises.
- Flexible pay options.
- Adjust pay so those on disability do not jeopardize benefits.
- Expanded expense reimbursement.
- Allow personal use of company assets.
- Training and education sponsorship.

## The Business Perspective

### Looming Conditions within the Labor Market:

- Over the next 5 years, 1/5 of all large US companies will be losing over 40% of their top executive management. (US Dept. of Labor Statistics –graph below)
- Over the same period, 35-44 year olds available to replace those retiring will decline by 15% creating a skilled labor shortage. (US Dept. of Labor Statistics)
- Additionally, by 2008, the labor market will have 1.7 million less 25-40 year olds to replace the 47 Million baby boomers that will be eligible for retirement. (US Dept. of Labor Statistics)



For an agency director or HR supervisor, these numbers paint a bleak staffing outlook. Within mental health/drug and alcohol treatment programs many senior and director level staff will be retiring within the next few years. The average age of substance abuse clinical staff is mid-forties to early fifties, and the average age of program directors are 50+ yrs (SAMSHA-Kaplan, 2003). This labor shortfall will need to be addressed to maintain current treatment delivery standards.

The aging out of senior treatment staff will only be exacerbated by the increase in healthcare service demands. Current healthcare services are overwhelming devoted to consumers of retirement age. Not only will there be less staff, but there will also be increased demand as the baby boomers start to require more healthcare services.

Currently, business managers are placing greater and greater emphasis on staff recruitment, development, and retention. These are vital not only for a company to compete within the marketplace, but required for any organization looking to expand its market presence. Staff recruiting and placement

agencies are big business and are now necessary to sustain to a company's ability to compete. The healthcare industry is not immune to this population shift. Actually, the future looks much worse for this industry. Healthcare has experienced growing staff shortages on all levels, and the need to further develop all untapped labor resources will drive agencies to consider including previously underutilized labor pools. Disabled, seniors, part-time, contract employees, and flexible staffing efforts are all examples of alternative staffing options. In the long run this labor shortage may influence the employment of consumers within agencies more than the other reasons.

## Summary

Granted, Choices may be the exception to the rule, but it could be strongly argued that many if not all of the methods discussed could be replicated in other programs producing like results. While Choices may be innovative in its approach, many of the basic operational principles are generally accepted within the business community as current best practices.

The system employed at Choices is proven and effective, as the delivery of mental health and drug and alcohol treatment services slowly change to one based increasingly on consumer driven delivery. Many will find Choices less innovative or "trendy", but rather a financial and therapeutic necessity.

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Choices of Long Beach, Inc.

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### **About Choices of Long Beach, Inc. dba Choices Recovery Services, "Choices"**

*Choices Recovery Services, a division of Choices of Long Beach, Inc. is a leader in the mental health rehabilitation and substance abuse treatment fields. Choices Program Model incorporates a multidisciplinary treatment "team" approach. Choices was recently recognized in two state-wide publication, and offers a complete range of recovery solutions including a menu of program components and a variety of both; licensed, certified, and approved residential options all with varying levels of supervision, program requirements, and program involvement. This allows for a continuum of services based on the needs of the individual program participant. Choices specialize in serving the "Special Needs" recovery community.*

*Choices Recovery Services operates ten properties: eight in Long Beach, one in Los Angeles and one in Santa Ana. All homes meet or exceed the standards required by the CA State Department of Alcohol and Drug Programs, CA Department of Mental Health, California Department of Corrections and Rehabilitation, Los Angeles and Orange County Sober Living Coalition (s), Orange County Sheriff's Facility Certification Program, California Association of Addiction Recovery Resources.*



(The "Choices House" – Three Versions by Past Residents)